Primary Care/Behavioral Health Integration

Thomas Smith, PhD, LMHC, LMFT, MCAP
Director, Behavioral Health Services

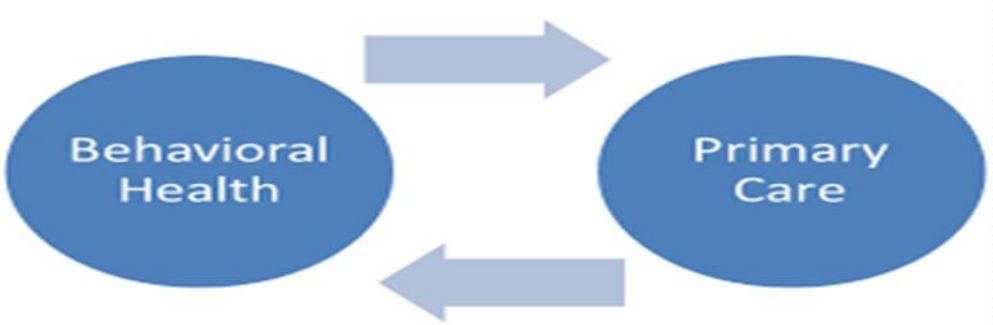
care | resource

Overview

- What is Integrated Care?
- The Rationale for Integration
- Integration Assessment
- Care Resource's Integrated Assessment and Goals
- Implementation
  - Identifying and Screening Patients
  - Assigning Responsibilities
- Benefits/Challenges
- Outcome goals

What is Integrated Care?

- “The systematic coordination of general and behavioral healthcare, based on the idea that physical and behavioral health problems often occur at the same time. “



Why Integrated Care?

- Reduced overlapping services
- Fewer medical tests
- Coordination of medications
- Decision-making support
- Fewer forms to fill out (maybe?)
- Better follow through, reduced wait times
- Better health outcomes
- Fewer emergency room and hospital admissions
- Higher satisfaction with services

Six Levels of Integration

- Coordinated
  - Communication (level 1 & 2)
- Co-located
  - Physical Proximity (level 3 & 4)
- Integrated
  - Practice Change (level 5 & 6)

Five Aspects of Integration

- Partnership of BH/PC
- Clinical Delivery
- Patient Experience
- Practice/Organization
- Business Model

"A Standard Framework for Levels of Integrated Care"
SAMHSA-HRSA Center of Integrated Health Solutions

Integration Assessment

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Clinical Delivery					
▸▸ Screening and assessment done according to separate practice models ▸▸ Separate treatment plans ▸▸ Evidenced-based practices (EBP) implemented separately	▸▸ Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges ▸▸ Separate treatment plans shared based on established relationships between specific providers ▸▸ Separate responsibility for care/EBPs	▸▸ May agree on a specific screening or other criteria for more effective in-house referral ▸▸ Separate service plans with some shared information that informs them ▸▸ Some shared knowledge of each other's EBPs, especially for high utilizers	▸▸ Agree on specific screening, based on ability to respond to results ▸▸ Collaborative treatment planning for specific patients ▸▸ Some EBPs and some training shared, focused on interest or specific population needs	▸▸ Consistent set of agreed upon screenings across disciplines, which guide treatment interventions ▸▸ Collaborative treatment planning for all shared patients ▸▸ EBPs shared across system with some joint monitoring of health conditions for some patients	▸▸ Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place ▸▸ One treatment plan for all patients ▸▸ EBPs are team selected, trained and implemented across disciplines as standard practice
Key Differentiator: Patient Experience					
▸▸ Patient physical and behavioral health needs are treated as separate issues ▸▸ Patient must negotiate separate practices and sites on their own with varying degrees of success	▸▸ Patient health needs are treated separately, but records are shared, promoting better provider knowledge ▸▸ Patients may be referred, but a variety of barriers prevent many patients from accessing care	▸▸ Patient health needs are treated separately at the same location ▸▸ Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider	▸▸ Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers ▸▸ Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services	▸▸ Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others ▸▸ Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop	▸▸ All patient health needs are treated for all patients by a team, who function effectively together ▸▸ Patients experience a seamless response to all healthcare needs as they present, in a unified practice

Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Practice/Organization					
▸▸ No coordination or management of collaborative efforts ▸▸ Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow	▸▸ Some practice leadership in more systematic information sharing ▸▸ Some provider buy-into collaboration and value placed on having needed information	▸▸ Organization leaders supportive but often colocation is viewed as a project or program ▸▸ Provider buy-in to making referrals work and appreciation of onsite availability	▸▸ Organization leaders support integration through mutual problem-solving of some system barriers ▸▸ More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components	▸▸ Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced ▸▸ Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers	▸▸ Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development ▸▸ Integrated care and all components embraced by all providers and active involvement in practice change
Key Differentiator: Business Model					
▸▸ Separate funding ▸▸ No sharing of resources ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share resources for single projects ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share facility expenses ▸▸ Separate billing practices	▸▸ Separate funding, but may share grants ▸▸ May share office expenses, staffing costs, or infrastructure ▸▸ Separate billing due to system barriers	▸▸ Blended funding based on contracts, grants or agreements ▸▸ Variety of ways to structure the sharing of all expenses ▸▸ Billing function combined or agreed upon process	▸▸ Integrated funding, based on multiple sources of revenue ▸▸ Resources shared and allocated across whole practice ▸▸ Billing maximized for integrated model and single billing structure

Heath B, Wise Romero P, and Reynolds K. A Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

Care Resource's Assessment

- Partnership of Behavioral Health and Primary Care (3)
  - Same facility – not the same offices
  - Collaboration was driven by need
  - Meet occasionally to discuss cases due to close proximity
  - Part of larger team but not well-defined
- Clinical Delivery (2)
  - Screening based on separate practices
  - Separate treatment plans
  - Separate responsibility for care

Assessment

- Patient Experience (3/4)
  - Patient needs are separate
  - Some warm hand-offs
  - Internal referrals, however they remain separate
- Practice/Organization (3)
  - Organization leaders supportive
  - Buy-in to making referrals work
  - Appreciation of onsite availability
- Business Model (3)
  - Separate funding and billing practices
  - Some shared expenses

Care Resource's Goal

- Partnership of Behavioral Health and Primary Care (6)
  - In the same space within the facility
  - One integrated system (EHR)
  - Consistent communication
  - Collaborate by team concept
  - Formal and informal meetings
- Clinical Delivery (5)
  - Consistent set of agreed screenings
  - Collaborative treatment planning

Goal

- Patient Experience (5)
  - Patient needs are treated by a team
  - Care is individualized response by a team (one stop shop)
- Practice/Organization (6)
  - Organization leaders strongly support integration as a practice model and change in service delivery
  - Resources available for development
  - Integrated care embraced by all providers and actively seeking change
- Business Model (5)
  - Blended funding based on contracts and grants
  - Billing function combined
  - Variety of ways to structure expenses

How did we implement?

- Hired the appropriate staff
  - Disease Case Manager (DCM)
  - Behavioral Health Specialist or Clinical Counselor (CC)
  - Medical Providers (MD)
  - Psychiatrist
- Created the space
  - Clinical Counselor and Disease CM located within the medical department

Implementation

- Access to Electronic Health Record (EHR)
  - All providers share the same EHR
  - Identified shared screenings
  - Creation of shared Treatment Plan
- One billing structure
  - Finance and Billing department are responsible for all provider billing

Identifying Patients

- Provider Huddles
  - MDs, Patient Care Assistants (PCAs), Clinical Counselor meet each morning to review patient schedules
  - High risk patients are prioritized
    - At risk for falling out of care (non-adherence)
    - Co-morbidities
    - Not virally suppressed
    - Mental Health or Substance Abuse
    - Positive results on screenings (at time of triage)
  - Those identified will be seen by the CC in addition to MD and DCM if necessary

Patient Encounters

- Patient is triaged and screened for vital signs
  - Vital Signs (BP, Heart Rate, Resp, Temp, Pulse Ox, BMI)
  - Health Screenings (pap smears, colon cancer , vaccines, diabetes, mammograms)
  - Tobacco Screening
  - PHQ-2 or PHQ-9
  - CAGE-AID

Encounters

- Patient roomed and providers are notified
  - MD is first to see patient for examination and discuss medical plan/goals including meeting with DCM or CC
  - Patient will meet with CC for further screening or assessment and the development of a treatment plan
  - DCM will be included as part of this process
  - Additional support will be included as available or patient will be linked to care with a “warm hand-off”
  - CC and DCM will follow up with patients between or at follow up MD appointments as recommended

Clinical Counselor

- Clinical Counselor introduces themselves to patient

"Dr. Zayas has identified you as someone that would benefit from additional services based on…"

"I would like to gather some additional information and develop some treatment goals that we can work on…"

"We will meet briefly when you return to see Dr. Zayas"

Screenings/Assessment

- Clinical Counselor will use additional screenings as needed
  - Drug Abuse Screening Test (DAST)
  - Alcohol Use Disorders Identification Test (AUDIT)
  - Lethality Assessment
  - Biopsychosocial
  - Brief Screening/Assessment
  - Short interventions

Responsibilities

- Clinical Counselor is responsible for the developing a shared treatment plan with the patient
  - Goals will include those indicated by MD, DCM, CC or additional providers (psychiatry, case management needs, more in-depth counseling needs)
  - The patient and CC will develop the plan together
    - Both CC and Patient will sign the treatment plan
    - DCM and MD will review the plan and co-sign at the same time or following the appointment

Responsibilities

- Follow up care will be arranged by CC based on need
  - Warm hand-offs will be utilized when able
  - Patients will be introduced to other mental health providers or case management
  - Patients will have appointments scheduled while meeting with CC
  - CC will schedule follow up appointments for short-term counseling sessions
- Consent Forms/Documentation will be completed as needed to ensure continuity of care

Disease Case Management

- Patients that are identified for DCM will be introduced
  - The DCM meets with the patient and completes in-depth health assessment
  - Barriers to care/health are identified and guides treatment
- Based on the assessment, specific treatment goals will be developed and patients will be reassessed on a regular basis
- DCM Termination – met goals

Billable Services

- Screenings – PHQ-9
- Mental Health Evaluation (Bio-Psychosocial)
- Brief Behavioral Health Status Exam Assessment
- Individualized Treatment Plan Development
- Treatment Plan Review
- Individual Counseling (Short-term)

Benefits

- Clear direction and plan to improve patient outcomes
- Integrated team approach
- Decrease of stigma attached to Behavioral Health
- Increase of utilization of services available to patients
- Shared EHR so that all providers are aware of progress
- Decrease in the “Silo” effect
- Improvement of overall outcomes

Challenges

- Length of Visit
- How the additional services are introduced
- Adherence to intensive program
- Avoiding the duplication of services/billing
- Referral process and follow up
- Managing shared goals – electronically
- Managing provider schedules

Outcome Goals

- Improvement in overall adherence
- Improvement with HEDIS Measures
- Viral Load Suppression
- Self-managed care
- Improvement in MH/SA outcomes
- Higher satisfaction of services

Questions???

Thank you!!!